## *SUBSTANCE ABUSE REHABILITATION PROGRAM*

SIGNIFICANT OTHER CONTACT AUTHORIZATION

I_____ authorize SARP, _____ to make personal contact with _____ to ascertain my substance abuse history in order to assist in determining my need for substance abuse treatment, and for the development of my individual rehabilitation/treatment plan if required. I understand that the purpose of this contact is to assist the drug and alcohol counselors at SARP, _____ to better understand my situation, and to more accurately identify and address potential problems with alcohol or other drugs. I also understand that any information regarding my substance abuse history is to be used strictly to determine my need for substance abuse treatment and to aid in the development of my treatment plan.

| | | |
|---|---|---|
| _____ | _____ | _____ |
| PATIENT'S NAME (PRINTED) | PATIENT'S SIGNATURE | DATE |

_____

PATIENT'S SSN

| | | |
|---|---|---|
| _____ | _____ | _____ |
| COUNSELOR'S NAME (PRINTED) | COUNSELOR'S SIGNATURE | DATE |
| _____ | _____ | _____ |
| COUNSELOR'S NAME (PRINTED) | COUNSELOR'S SIGNATURE | DATE |

| | | | |
|---|---|---|---|
| Patient Name | | Rank/Grade | Sex |
| SSN/Identification Number | Status | Date of Birth | |
| Branch of Service | Organization | | |
| Sponsor's Name | Relationship to Sponsor | | |